State of Indiana

REIMBURSEMENT FOR SERVICES PROVIDED BY PHYSICIANS, LIMITED LICENSE PRACTITIONERS, AND NON-PHYSICIAN PRACTITIONERS

I. A. Summary of the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology

All services provided by physicians, limited license practitioners, and non-physician practitioners will be reimbursed according to a statewide fee schedule based on a Resource-Based Relative Value Scale (RBRVS). This includes services provided by:

Physicians and Limited License Practitioners

- doctors of medicine,
- osteopaths,
- physician or primary care group practices,
- optometrists,
- podiatrists,
- dentists who are oral surgeons,
- chiropractors, and
- health service providers in psychology.

Non-Physician Practitioners

- audiologists,
- speech therapists,
- licensed psychologists
- independent laboratory or radiology providers,
- dentists who are not oral surgeons,
- social workers certified through the American Academy of Certified Social Workers,
- advance practice nurses,
- physician assistants, and
- mental health professionals.

The components of the RBRVS methodology used to develop the fee schedule include the Medicare-based Relative Value Units (RVUs), the Geographic Practice Index (GPCI), and a conversion factor. RVUs for each procedure were developed by HCFA to represent the resource-use associated with individual procedures. These RVUs were adjusted using the Medicare Urban locality GPCI to reflect work, practice, and malpractice costs in Indiana. The following GPCI values were multiplied by the Medicare-based RVUs to obtain Indiana-specific RVUs for each procedure:

- Work: 0.980
- Practice Expense: 0.905
- Malpractice: 0.516

The conversion factor was developed using Indiana Medicaid claims data from fiscal year 1992 and specific policy assumptions relative to the Indiana Medicaid program. To determine the payment rate for each procedure under the RBRVS fee schedule, the Indiana-specific RVU for each procedure is multiplied by the conversion factor according to the following calculation:

Payment Amount = (Indiana RVU x Indiana Medicaid Conversion Factor)

The Indiana Medicaid conversion factor is $28.61.

I. B. Summary of exceptions to the RBRVS reimbursement methodology

1. For procedures where no Medicare RVU exists, the RBRVS fee schedule amount was established using RVUs from other state Medicaid programs or developed specifically for the Indiana Medicaid program. For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement is based on the fee value of the national Medicare clinical laboratory fee schedule.

2. The Medicaid office developed RBRVS fee schedule amounts for certain maternity and primary care procedures to give special consideration to the importance of maternity and primary care services in the Indiana Medicaid program. The RBRVS fee schedule amounts for the following HCPCS codes were not developed using the RBRVS methodology:
   - 59000 - 59130,
   - 59136 - 59320,
   - 59350 - 59426,
   - 59500 - 59851, and
   - 99211.

3. The RBRVS fee schedule amounts for anesthesiology procedures were developed using the total base and time units for each procedure multiplied by the Indiana Medicaid conversion factor for anesthesiology, $13.88.

4. The RBRVS fee schedule amounts for services of dentists in calendar year 1994 were developed based on fiscal year 1992 charges and the percentage difference between physician and LLP submitted charges for fiscal year 1992 and RBRVS fee schedule amounts. The Medicaid agency may set reimbursement for specific dental procedures using a different methodology in order to preserve access to the service. Effective 8/1/95, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage (20%) determined by the Medicaid agency. In order to address a crisis, the agency complied with the above Plan to use a different methodology in order to preserve access to dental services by setting reimbursement rates for most dental procedures equal to 100% of the 75th percentile of the rates reported by the American Dental Association for the East North Central Region (ADA-ENC), effective May 1, 1998. The ADA-ENC-based rates will be adjusted annually for inflation, using the Consumer Price Index – Urban, Dental (CPI-UD).

II. Application of reimbursement methodology for services provided by physicians and limited license practitioners (LLPs)

1. Reimbursement for services provided by physicians and limited license practitioners (LLPs), except for services described in subdivisions two (2) through six (6) below, will be equal to the lower of:

   - the provider's submitted charges for the procedure, or
   - the established RBRVS fee schedule allowance for the procedure.

2. Services provided by assistant surgeons will be reimbursed at twenty percent (20%) of the RBRVS fee schedule amount for the procedure and surgeons at sixty-two and one-half percent (62.5%) of the RBRVS fee schedule amount for the procedure.

3. Reimbursement for all services is subject to the global surgery policy as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services. The global surgery policy will not apply to the following codes:

   - 59410 - vaginal delivery, including post-partum care, and
   - 59515 - caesarean delivery, including post-partum care.

4. Reimbursement for services provided by physicians and LLPs is subject to the policy for supplies and services incident to other procedures as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services.

5. Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections.

6. Reimbursement for services provided by physicians and LLPs is subject to the site-of-service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the RBRVS fee schedule amount for the procedure. These procedures are identified using the site-of-service indicator on the Medicare fee schedule database.

III. Application of the RBRVS reimbursement methodology for services provided by non-physician practitioners (NPPs)

1. Reimbursement for services provided by non-physician practitioners (NPPs), except services described in subdivisions 2 and 3 below, will be equal to the lower of:

   - the submitted charge for the procedure, or
   - the established RBRVS fee schedule amount for the procedure.

2. Outpatient mental health services provided by:

- social workers who are either certified through the American Academy of Certified Social Workers (ACSW) or holding masters of social work (MSW) degrees,
- psychologists with basic certificates, and
- licensed psychologists

in a physician-directed outpatient mental health facility in accordance with 405 IAC 1-6-13 and 405 IAC 1-7-20 will be reimbursed at seventy-five percent (75%) of the RBRVS fee schedule amount for that procedure.

3. Services provided by independently practicing respiratory therapists and advance practice nurses will be reimbursed at seventy-five percent (75%) of the RBRVS fee schedule amount for that procedure.

IV. Additional provisions related to the RBRVS reimbursement methodology

1. The RBRVS fee schedule will be reviewed annually and adjusted as necessary, taking into account the Medicare fee schedule proposed by the Health Care Financing Administration to take effect January 1 of the following calendar year.

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PHARMACY SERVICES

Pharmacy services are reimbursed as follows:

1. Legend Drugs - Payment is based on the lowest of:

   (A) Maximum Allowable Cost (MAC) as established by the HCFA, as of the date dispensed, plus a $4.00 dispensing fee;

   (B) Estimated Acquisition Cost (EAC), currently defined as Average Wholesale Price (AWP) minus 10%, as of the date dispensed, plus a $4.00 dispensing fee;

   (C) The provider's usual and customary charge for the drug to the general public (which is the charge to be submitted to Indiana Medicaid), as of the date dispensed;

   minus a recipient copayment amount, where applicable, as set out in Attachment 4.18-A.

   The upper limit for a multiple source legend drug for which a specific upper limit (MAC) has been established does not apply when a physician indicates the necessity for the dispensation of a particular brand name drug corresponding to the multiple source drug by handwriting the words "Brand Medically Necessary" on the form.

2. Non-Legend (OTC) Drugs and Medical Supplies - Payment is based on the lower of:

   (A) One hundred fifty percent (150%) of:

   - the State maximum allowable cost for the drug, as set out in the Medicaid Pharmacy Provider Manual and amendments thereto, in the quantity dispensed, as of the date dispensed, minus any applicable copayment amount;

   - the Average Wholesale Price (AWP) for the supply item, in the quantity dispensed, as of the date dispensed; or

   (B) The provider's usual and customary charge for the drug or medical supply to the general public (which is the charge to be submitted to Indiana Medicaid), as of the date dispensed, minus any applicable drug copayment amount.

FREE STANDING CLINIC SERVICES

The Office of Medicaid Policy and Planning (OMPP), in accordance with 42 CFR 447.325, will not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

OUTPATIENT HOSPITAL SERVICES

The reimbursement methodology for all covered outpatient hospital services is based on an established fee schedule. The established fee amounts are as follows:

(a) The fixed fee for outpatient surgical procedures is established using a blended rate based half on the 1993 Medicare ambulatory surgical center (ASC) rate and half on the Indiana Medicaid statewide median allowed amount for that procedure in state fiscal year (FY) 1992. The Office of Medicaid Policy and Planning will classify outpatient surgical procedures not classified into an ASC group by Medicare into one of the nine ASC groups designated by Medicare, or additional payment groups.

(b) The fixed fee for emergency outpatient services is established at the Indiana Medicaid statewide median amount paid per service during state FY 1992.

(c) The fixed fee for non-emergency services provided in an emergency room is established using the statewide median amount paid for non-emergency services during state FY 1992, less any applicable co-payment amount.

(d) The fixed fee for laboratory procedures and the technical component of radiology procedures is established at 95 percent of the Medicare allowance that was in effect in 1992 prior to Medicare's adoption of the Resource Based Relative Value Scale (RBRVS) reimbursement methodology.

(e) The fixed fee for all other outpatient procedures is established based on the Indiana Medicaid statewide median amount paid per service during state FY 1992.

The Office of Medicaid Policy and Planning will examine reimbursement for outpatient services to ensure that revisions contain appropriate incentives for provision of primary and preventive care.

RURAL HEALTH CLINIC SERVICES

Sec. 1. Pursuant to 42 CFR 447.371, Indiana Medicaid will reimburse rural health clinic services in the following manner:

a. The rural health clinic services including independent health clinics as defined in Section 440.20(b), will be reimbursed at the reasonable cost rate per visit determined by the designated regional Medicare contractor. Each certified clinic will directly provide the contractor with the required cost data as needed to determine the all-inclusive rate for the particular clinic at the beginning of the report period.

b. Rural health clinics referred to as provider clinics, which are an integral and subordinate part of a hospital, skilled nursing facility, or home health agency will be reimbursed by the same rate setting method used for the parent facility.

   Payments made according to a cost reimbursement rate per visit will be subject to reconciliation after the close of the reporting period, in accordance with 42 CFR 405.2427. Indiana will use the final rate determined by the intermediary based on actual cost and visits for the reporting period.

c. The "other ambulatory services," as described by 42 CFR 440.20(c), are those services Indiana will reimburse in addition to "rural health clinic services." Examples are: transportation, durable medical equipment, prosthetic devices, eye glasses, prescribed drugs, physical therapy and related services, optometric services, chiropractic services, podiatry services, dental services (including those services rendered in conjunction with the EPSDT Program), and others listed in the State Plan and covered by the Indiana Medicaid Program in other settings.

   Indiana Medicaid will reimburse for such services according to its customary method of payment. The rate for these services will be determined on a fee for service basis as in other settings under the State Plan, but will not exceed the upper limits as required by 42 CFR 447. If other reimbursement options become available at a later date, Indiana Medicaid reserves the right to re-evaluate and change its present method.

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HOSPICE SERVICES

Reimbursement for hospice care shall be made according to the methodology and amounts calculated by the Health Care Financing Administration (HCFA). Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the hospice wage index published by HCFA.

Medicaid reimbursement for hospice services will be made at one of four all-inclusive per diem rates for each day in which a Medicaid recipient is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

(1) Routine Home Care. The hospice will be paid at the routine home care rate for each day the recipient is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(2) Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for over half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty four (24) hours a day.

(3) Inpatient Respite Care. The hospice provider will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(4) General Inpatient Care. Subject to the limitations below, the hospice provider will be paid at the general inpatient rate for each day the recipient is in an approved inpatient hospice facility and is receiving general inpatient care for pain control or acute or chronic symptom management which cannot be managed in other settings.

HOSPICE SERVICES, continued

When routine home care or continuous home care is furnished to a recipient who resides in a nursing facility, the nursing facility is considered the recipient's home. (See Attachment 4.19-D, page 65 for the description of an additional per diem amount to be paid directly to the hospice provider for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services.)

Reimbursement for inpatient respite care or general inpatient care is available only for a recipient who resides in a private home. Reimbursement for inpatient respite care or general inpatient care is not available for a recipient who resides in a nursing facility.

Limitations on payments for inpatient care:

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid recipients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice provider or its contracted agent(s). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice provider receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows:

(1) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).
(2) If the total number of days of inpatient care to Medicaid hospice recipients is less than or equal to the maximum number of inpatient days computed in subdivision (1), then no adjustment is made.
(3) If the total number of days of inpatient care to Medicaid hospice recipients is greater than the maximum number of inpatient days computed in subdivision (1) above, then the payment limitation will be determined by the following method:
(A) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.
(B) Multiplying excess inpatient care days by the routine home care rate.
(C) Adding together the amounts calculated in subdivisions (3)(A) and (3)(B) above.
(D) Comparing the amount in subdivision (3)(C) above with total reimbursement made to the hospice provider for inpatient care during the cap period. The amount by which total reimbursement made to the hospice provider for inpatient care for Medicaid recipients exceeds the amount calculated in subdivision (3)(C) above is due from the hospice provider.

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HOSPICE SERVICES, continued

Reimbursement for physician services:

The basic payment rates for hospice care represent full reimbursement to the hospice provider for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice provider. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

Reimbursement for a hospice employed physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Indiana Medicaid reimbursement methodology for physician services. These services will be billed by the hospice provider under the Medicaid hospice provider number. The only physician services to be billed separately from the hospice per diem are direct patient care services. Laboratory and x-ray services relating to the terminal condition are included in the hospice daily rate.

Reimbursement for an independent physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Indiana Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice provider under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program when those services relate to the terminal condition. These costs are included in the daily rates paid and are expressly the responsibility of the hospice provider.

Volunteer physician services are excluded from Medicaid reimbursement. However, a physician who provides volunteer services to a hospice may be reimbursed for non-volunteer services provided to hospice patients. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid patients on the same basis as other hospice patients. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment for all physician services rendered to Medicaid patients.